100 Broadway Menands ALBANY 12241 (518) 474-6674
State Office Building 44 Hawley Street BINGHAMTON 13901 (607) 721-8356
180 Livingston Street BROOKLYN 11248 (718) 802-6600
State Office Building 125 Main Street BUFFALO 14203 (716) 847-3158
175 Fulton Avenue HEMPSTEAD 11550 (516) 560-7700
130 Main Street W. ROCHESTER 14614 (716) 238-8300
State Office Building 333 East Washington St. SYRACUSE 13202 (315) 428-4484

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

STATEMENT FOR A GOVERNMENT ENTITY THAT A BUSINESS DOES NOT REQUIRE WORKERS' COMPENSATION AND/OR DISABILITY BENEFITS COVERAGE

Applicant's Name	Business or Trade Name, If Different
Applicant's Home Address	Business Address (Physical Location), If Different
Home Telephone Number	Business Telephone Number, If Different
Type of Business	Federal Employer Identification Number

Under penalty of perjury, I certify that the above business does not hire sub-contractors and does not require
☐ Workers' Compensation Coverage ☐ Disability Benefits Coverage because:

☐ the business is owned by one individual with no employees and is not a corporation.

☐ the business is a partnership under the laws of New York State, and there are no employees.

☐ the business is a one or two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation, and there are no employees.

☐ the business does not require disability benefits coverage at this time since it has not employed one or more individuals on each of at least 30 days in any calendar year.

☐ (Please specify other reason)

I also agree to acquire appropriate worker's compensation and disability benefits coverage for the above business, if circumstances change so that such coverage is required.

Date Signed: _____ By: _____
(Signature of Business Owner, Partner or Corporate Officer)

Requested Effective Dates: from _____ to _____ Title: _____
(One Year Maximum)

(Business Owners: Please Send Completed Application to nearest WCB Enforcement Unit.)

NOTICE

ANY FALSE STATEMENT, REPRESENTATION, OR CONCEALMENT WILL SUBJECT YOU TO FELONY CRIMINAL PROSECUTION, INCLUDING JAIL AND CIVIL LIABILITY IN ACCORDANCE WITH THE WORKERS' COMPENSATION LAW

In conformance with Sections 57 and 220 Subd. 8 of the Workers' Compensation Law, based on the foregoing certification made by the above business, the Workers' Compensation Board has no objections, at this time, to the issuance of requested permits or contracts.

Date Signed: _____ By: _____
(Signature of WCB Employee)

Telephone Number: _____ Title: _____

Please Note: This Statement is valid only from _____ to _____ (one year maximum). At the expiration of this term, if the business continues to be named on a permit or contract issued by a government entity, the business must provide that government entity with a new Statement. **The business must provide a Certificate of Workers' Compensation and Disability Benefits Coverage to the government entity if circumstances change so that such coverage is required during this period.** Further, it is understood that the Board reserves the right to request revocation of the permit or contract if, after investigation, it is found that the above business is required to have workers' compensation and/or disability benefits coverage.

****This form cannot be used to waive the workers' compensation rights or obligations of a subcontractor****